5-22-1997

DDASaccident100

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date: 19/04/2006

Accident number: 100

Accident time: not recorded

Accident Date: 22/05/1997

Where it occurred: Qazi Kariz village, Darman District, Kandahar

Country: Afghanistan

Primary cause: Unavoidable (?)

Secondary cause: Field control inadequacy (?)

Class: Excavation accident

Date of main report: [No date recorded]

ID original source: none

Name of source: MAPA/UNOCHA

Organisation: [Name removed]

Mine/device: POMZ AP frag

Ground condition: bushes/scrub

ditch/channel/trench

soft

Date record created: 24/01/2004

Date last modified: 24/01/2004

No of victims: 1

No of documents: 1

Map details

Longitude:

Latitude:

Alt. coord. system:

Coordinates fixed by:

Map east:

Map north:

Map scale: not recorded

Map series:

Map edition:

Map sheet:

Map name:

Accident Notes

inadequate metal-detector (?)

inadequate investigation (?)

handtool may have increased injury (?)

squatting/kneeling to excavate (?)

use of pick (?)

Accident report

At the time of the accident the UN MAC in Afghanistan favoured the use of two-man teams (usually operating a one-man drill). The two would take it in turns for one to work on vegetation cutting, detecting and excavation, while the other both rested and supposedly "controlled" his partner.

An investigation on behalf of the UN MAC was carried out and its report made available. The following summarises its content.

The victim had been a deminer for five years. It was seven months since his last revision course and 24 days since his last leave. The accident occurred in an area described as agricultural – a "grapes field". A photograph showed that the accident occurred in a gully [a collapsed irrigation channel?] on ground that had light scrubby bush but no vines in evidence.

The investigators determined that the minefield was old and the mines had fallen and become buried. The victim did not mark the detector reading point before investigating with a pick, so triggered the mine which was identified as a POMZ from "fragments found". The victim's pick and helmet were damaged.

The Assistant Team Leader said that the victim marked the detector reading and triggered the mine when he reached the second mark (centre of three stones) with the pick. He said the deminer should have been using a bayonet rather than the pick in soft ground.

The victim's partner said that the victim marked the detector reading and triggered the mine when he reached the second mark (centre of three stones) with the pick. He said he was doing his job properly. He said they should not be allowed to use the pick in soft ground.

The victim said that he marked the detector reading and the mine went off as he reached the second point.

The Section Leader said that the deminer did not mark properly and his carelessness caused the accident. The victim should have used the bayonet to move towards the reading point.

Conclusion

The investigators concluded that the victim breached technical and safety procedures by using the pick in an area where it is not needed, then using the pick improperly having not marked the detector reading point.

Recommendations

The investigators recommended that the Section Leader should be disciplined for poor management, that no one should be allowed to investigate the detector "reading point" with a pick, and that the demining group should conduct training on the proper use of the pick immediately.

Victim Report

Victim number: 133

Name: [Name removed]

Age:

Gender: Male

Status: deminer

Fit for work: yes

Compensation: 6,429 Rs

Time to hospital: not recorded

Protection issued: Helmet
Thin, short visor

Protection used: Helmet; Thin, short visor

Summary of injuries:

INJURIES

minor Arm

minor Chest

minor Hand

minor Neck

COMMENT

See medical report.

Medical report

The victim's injuries were summarised as superficial injuries to his left arm, left hand and left side of his chest.

There were two medic's sketches on file, one showing no injury to his hand. The other sketch is reproduced below.

A site-medical report added superficial neck injuries to the record. A more detailed report mentioned finger injuries.

The demining group reported that the victim suffered superficial injuries to his chest and neck and left arm and left hand. The insurers were informed on 23rd May 1997 that the victim had sustained injuries to the left side of his neck, his chest, arm and fingers.

Compensation of 6,429 Rs was paid on 13th August 1997.

Analysis

The primary cause of this accident is listed as *"Unavoidable"* because, despite the investigator's opinion, there was no evidence to suggest that the victim had not been working in the way in which he was trained. There is some question over whether the method of excavation was appropriate, and the methods used are determined by senior management. In deference to the investigators, the secondary cause is listed as a *"Field control inadequacy"* because the victim may have been working inappropriately and his error not corrected.

The general agreement that the mine detonated on the second marker may indicate that the detector signal had not been marked accurately. But this may have been due to the inadequacy of the detector, as recorded in the reports of many other Afghan accidents around this time (when the Schiebel AN/19 was still in use).

The use of a pick and a squatting position to "excavate" were both in breach of UN requirements, but not in breach of the demining group's unauthorised variations to those requirements. The failure of the UN MAC to either listen to field feedback and adapt the SOPs for local conditions, or enforce their own standards may be seen as a management failing.

The agency that was used to make investigations for the UN MAC (based in Pakistan) at this time was frequently constrained by lack of funds, staff and transport. At times their movement was constrained by safety concerns. As a result, investigations were frequently delayed by weeks, meaning that an assessment of the site at the time of the accident was impossible.